Department of Alcohol & Drug Programs

Companion Guide Appendix

July 8, 2011

Version 4.4

Appendix Table of Contents

1.0 Change Record

Version	Author	Date	Changes, Comments
Version 1.0	Michael Freeman	11/07/2008	Original
Version 2.0	Michael Freeman	1/16/2009	- Updated Adjustment Reason Codes - Added PLB Adjustment Table - Updated Void & Replace Scenarios - Added Submitting Files to ADP section - Added PLB Segment Information - Added 277U Information
Version 3.0	Michael Freeman	5/18/2009	- Revised File Naming Conventions - Finalized Adjustment Reason Codes List - Included Additional Void and Replacement Scenario for Split Claims - Added Split Claims Information Section - Added EPSDT Information Section - Added Additional 835 Data Section
Version 4.0	Michael Freeman	10/20/2009	- Updated PWK Section - Updated Adjustment Reason Codes List - Added Bridge Resubmission File Naming Convention
Version 4.1	Michael Freeman	11/03/2009	- Clarification Added to PWK Section - Correction to Void and Replacement scenarios 13.3 and 13.10

Version 4.2	Michael Freeman	12/07/2009	- Added CO.143 to Adjustment Reason Code Table
Version 4.3	Michael Ellison	8/13/2010	Made recommended technical corrections/edits from Chris Dicely, FMAB to Section 15.3 Table C column heading and CO 143, A1, PR-1 code descriptions.
Version 4.3	Michael Ellison	12/01/2010	Made recommended technical corrections/edits from Susan King and Chris Dicely to Section 15.3 Table C, CO/11, CO/16/N354, CO/22, CO/129, CO-138, CO/A1/N421, and PR-1 code descriptions.
Version 4.3	Michael Ellison	1/21/2011	Made change to Table 12.0 clarifying when a claim can be replaced and use of PCCN for when replacing a voided claim.
Version 4.4	Christopher Dicely	7/08/2011	Added new § 15.0 (OHC Billing Scenarios) incorporating and expanding instructions from ADP Bulletin #11-01 (former § 15.0 is now § 16.0) Added notes on COB balancing edit (CO/A1/N480) to Table C.

2.0 Submitting files to ADP

2.1 Preparing Files for Upload

1. Files must be named using the following naming convention.

   ADP-[CC or DDDD]-[TXN]-[MMDDYYYY]-[NNN].DAT for the unzipped ASCII file (also referred as internal file)

   ADP-[CC or DDDD]-[TXN]-[MMDDYYYY]-[NNN].ZIP for the compressed zip file (also referred as external file).

   - CC = County Code or DDDD = Direct Provider Code.
   - TXN = 837P or 276
   - MMDDYYYY = EDI file submission date from county, MONTH/ DAY/ YEAR
   - NNN = Any three digit number to maintain a unique file name
2. The external zip file name must match the internal ASCII filename (except for the file extension)
3. The zipped file must contain only one internal file.
4. The zipped file must be password protected using the standard password. The standard password is available in the ITWS "System Messages" section of the system.
5. Files that are Bridge Resubmissions must use the naming convention below. This naming convention is the same as a regular file with the addition of "BR".

   ADP-BR-[CC or DDDD]-[TXN]-[MMDDYYYY]-[NNN].DAT for the unzipped ASCII file (also referred as internal file)

   ADP-BR-[CC or DDDD]-[TXN]-[MMDDYYYY]-[NNN].ZIP for the compressed zip file (also referred as external file).

   - BR = Bridge Resubmission
   - CC = County Code or DDDD = Direct Provider Code.
   - TXN = 837P or 276
   - MMDDYYYY = EDI file submission date from county, MONTH/ DAY/ YEAR
   - NNN = Any three digit number to maintain a unique file name

2.2 Uploading EDI Files via ITWS

1. Log on to ITWS (https://mhhitws.cahwnet.gov) with your assigned user name and password.
2. From the Systems tab, select Short-Doyle/Medi-Cal – EOB (for ADP).
3. From the Functions tab, select Upload.
4. Click the Browse or Add button to choose the zip file to upload.
5. Click the Upload button.
6. Select "Phase II Files Processing Status" link from the Functions tab to see the status of your file.

3.0 Submitter's EIN – ISA06, GS02

ISA06 and GS02 are required data elements that will be strictly enforced by checking to make sure they are correct based on the ITWS submitter. The Interchange Sender ID must be the county's or direct provider's EIN, which will be verified and the claim will be denied if incorrect.

4.0 Split Claims

When a claim is submitted with multiple service lines, the situation may arise where one or more of the service lines are approved, while the remaining service lines may be denied. In order to provide timely notification to submitters regarding denied service lines SD/MC Phase 2 will automatically split claims of this nature and return back the denied service lines immediately. The approved service lines will continue in the payment cycle. Split claiming would not apply to claims submitted with only one service line Split Claim Example

A claim is submitted with four service lines (A, B, C, and D). Service lines A and C are denied, while B and D are approved. Within the SD/MC Phase 2 system two claims are created from the single claim submitted: one approved claim (with services B and D) and one denied claim (with services A and C). Notification of the denied claim is returned to the submitter via an 835 transaction. The approved claim continues in the payment cycle until payment information is sent to the submitter via a separate 835 transaction.

4.1 Split Claims and Void and Replacement

The separate claims resulting from claim splitting can be voided and replaced, using the Payer Claim Control Numbers (PCCNs) supplied for each of the resulting claims. A detailed scenario is included in section 12.3.

5.0 Claim Supplemental Information - PWK Segment

The PWK segment in Loop 2300 of the 837 transaction set is used to identify that the claim requires manual review of either eligibility documentation or specific delay reason codes. This will allow ADP to identify claims that need additional information sent, hold the claim until the paperwork is received, and to complete a manual override of a claim.

There are two situations where the presence of a PWK segment will cause the SD/MC Phase 2 system to act:

1) If there is documentary evidence that a beneficiary was actually eligible for a service that was previously (or would be) denied for eligibility reasons - the submitter may include a PWK segment with a report type code = "OZ" this will cause the claim to be routed for manual review prior to adjudication.

2) When a submitter uses specific late reason codes the submitter is required to include a PWK segment with report type code = "CT" for manual review of the claim prior to adjudication.

Please refer to section 15.1 Table A – Delay Reason Codes, to determine which delay reason codes require the PWK segment.

When using the PWK segment the following field values should be used:

Field Name	Field Value
PWK01	"OZ" or "CT"
PWK02	"BM" or "FX"
PWK05	"AC"
PWK06	A control number that ties the request, to the paper you will be sending via fax or mail.

6.0 EPSDT Information

Per the 837P HIPAA Implementation Guide, submitters are required to populate the EPSDT Indicator (Loop 2400 SV111) if "*Medicaid services are the result of a screening referral."* Submitters should be aware that SD/MC Phase 2 does not use this field during adjudication. SD/MC Phase 2 adjudication uses the aid code of the beneficiary as the basis for determining whether the claim is classified as being EPSDT or not. The result of this determination is returned to the submitter on the 835 (Loop 2100, Segment NM1*74 – Corrected Patient/Insured Name, field NM109).

7.0 Payer Claim Control Number

Every claim reported on an 835 or 277 transaction will identify a Payer Claim Control Number (PCCN) in the fields described for that purpose in the appropriate Implementation Guide. The PCCN is the unique ID for the claim in ADP's system.

8.0 Provider Level Adjustments - PLB Segment

In Phase II, the PLB segment in the 835 will be used to convey provider level adjustment information. Provider level adjustments occur when there is a blanket reduction at the provider level that cannot be tied to a specific claim line or service line amount. For example, ADP may make PLB adjustments during cost settlement, an audit or a legal attachment (such as from an IRS levy). These adjustments are not tied to a specific claim or service line amount, but they are tied to a provider. The table containing all PLB adjustments is in section 15.4 on page 22.

9.0 277 Unsolicited Claim Status Information

The 277U is an unsolicited claim status transaction. This means that the 277U will be sent without the trading partner requesting it to be sent. For ADP, a 277U will be sent based on three business rules: (1) Awaiting manual override – immediately after status occurs. (2) Awaiting fax validation after 7 days from the date the file was uploaded to ITWS. (3) Awaiting payment information – immediately after the claim is adjudicated and approved.

10.0 Additional 835 Data

ADP will make use of the 835 to communicate a number of pieces of information that Trading Partners may find helpful.

In the 835 2100 Loop, Segment NM1*74 Corrected Patient/Insured Name, Data Element NM109, the following information will be provided:

- County Code (2 bytes alphanumeric) – the county code of the submitting county.
- Approved Aid Code (2 bytes alphanumeric) – the aid code used to adjudicate the claim.
- CIN (9 bytes alphanumeric) – the CIN of the beneficiary on the claim.
- County of Responsibility (2 bytes alphanumeric) – the county code of the county identified on MEDS as being responsible for the beneficiary.
- EPSDT Indicator (1 byte alphanumeric) – indicates whether the claim was identified as an EPSDT claim or not. This field is determined during adjudication and is based upon the aid code of the beneficiary. Valid values are "Y" or "N".
- Submission File Name (37 bytes alphanumeric) – the file name of the 837 submission file on which this specific claim was submitted on. ITWS appends the actual date of submission to the front of the file name (file naming conventions are described in section 2.1).

11.0 Void Claims

A void claim allows Counties and Direct Providers to request that ADP treat a previously-approved claim as null and void. Trading partners should void claims when the trading partner identifies that a claim that was submitted and paid should not have been billed to Drug Medi-Cal. If some of the claim information was inaccurate, but the claim should still have been billed, see Replacement Claims below.

Claims can only be voided when they have been approved and finalized (that is, when an 835 has been issued indicating the claim is approved and paid or approved but payment deferred.) The voiding claim is identified with a Claim Frequency Type Code (CLM05-3) of "8". The PCCN of the claim being voided must be placed as data element REF02 in the Original Reference Number segment of the voiding claim. Once a claim has been voided, it cannot be voided again, nor can it be replaced.

The Claim Payment Information (Loop 2100) reported for the Void claim on the 835 mirrors the approved claim with the exception of all dollar, units of time, and units of service fields. Claim Payment Information (Loop 2100) will also contain the Payer Claim Control Number of the voiding claim as an Original Reference Number for the voided claim, to indicate why the voided claim was being reversed. These fields will be the negative of the original approved claim. The only exception to this rule is the Maximum Allowed Amount, which will remain positive.

12.0 Replacement Claims

A replacement claim allows Counties or Direct Providers to replace a previously finalized (approved and paid, approved and payment deferred, or denied, as reported on an 835 transaction) claim. Trading partners should replace claims when they have identified either that the previously-submitted claim was submitted with incorrect information, or that service lines were erroneously included in or omitted from the claim.

The replacement claim is identified with a Claim Frequency Type Code (CLM05-3) of "7" (CFT=7). The PCCN of the claim being replaced must be placed as data element REF02 in the Original Reference Number segment of the replacement claim. The successful replacement of an original approved claim will create a system-generated transaction that is similar to a void. The replacement claim will be adjudicated as an original claim, except that it will retain the original received date. All replacement claims will be reported on the 835.

However, only a claim that has not been replaced or voided can be replaced. If a claim has been replaced successfully, then the original claim (CFT=1, see Section 13.1 below) is no longer available for void or replacement. Therefore, only a replacement claim can be voided or replaced. Approval or denial adjudication results of the original claim (CFT=1) and replacement claim (CFT=7) is not a factor when replacing a claim.

Trading Partners must use the most current PCCN in the next void or replacement in the sequence. Do not the use the PCCN of the original claim (CFT=1).

If a replacement claim is submitted, but did not successfully replace the previously submitted claim (the 835 does not correct and reverse the previously submitted claim), then the replacement claim cannot be replaced. However, in this scenario, the prior claim would be available for replacement, and the prior claim's PCCN is used.

13.0 Void and Replacement Scenarios

Following are a number of scenarios that describe specific data elements on both the submitted 837 and the corresponding 835 transaction involved in Void and Replacement transactions.

13.1 Key Data Elements

Key data elements used in the scenarios are listed below, along with a description of their purpose.

HEADING	TXN	DESCRIPTION
Seq. #	N/A	Number assigned to each transaction in the scenario indicating sequence of events.
Txn		Identifies which transaction is being represented
CLM05-3 (Claim Type)	837	Identifies the transaction as an original (1), replacement (7), or void (8) (other valid values are 2,3 or 4 each is treated as not being a replacement or a void claim)
Claim Amount	837 (*)	Representative of the value of the claim.
Services	837 (*)	Reflects the presence of one more service in alphabetical increments (A = service 1, B = service 2, etc.)
Units of Service	837	Identifies the units of service (SV104 for Professional)
Rec. Date	837 (*)	The claim received date via ITWS.
Calc. Date	837 (*)	The date the target claim was received by the State. This feature, pertaining only to replacement claims, allows those claims to preserve the original claim's received date.

CLM01	837	This is the Unique ID submitted for the claim. This number is NOT used for Void and Replacement processing.
ORN	837	The Original Reference Number is Payer Claim Control Number from the 835 of the target claim. Every void or replacement claim is matched to its target using the ORN.
Adjudication Result	N/A	The status assigned to the claim as a result of processing (App = Approved, Den = Denied, V = Void). To build the scenarios, the status is important for the next step, not the reason for the status; therefore, no reasons for denied claims are included.
835 Date	835 (*)	Representative of when the 835 was produced.
CLP01	835	This is Claim Submitter's Identifier (Unique ID) on the 835 that is echoed back from CLM01 value submitted on the 837.
CLP02	835	The status of the claim as reported on the 835 (1 = Approved, 4 = Denied, 22 = Reversal)
CLP03	835	Total Claim Charge Amount – the amount billed on the claim.
CLP04	835	Claim Payment Amount – the amount actually to be paid.
CLP07	835	This is the Payer Claim Control Number generated by the claims processing system for each approved or denied claim. The number is used in the Original Reference Number segment for void and replacement claims.
SVC05	835	Number of units paid.

Negative numbers are enclosed by parentheses (nn)

* Not an actual implementation guide defined field, representational use only.

13.2 Original Denied

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	$100	A	4	4/1/09	4/1/09	3456		Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	4/2/09	3456	4	$100	$0	8881	0

13.3 Original Approved, Void Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	$100	A	4	4/1/09	4/1/09	123		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	123	1	$100	$100	9991	4

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	8	$100	A	4	6/1/09	6/1/09	333	9991	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	123	22	($100)	($100)	9991	(4)

13.4 Void Denied

Using the scenario 12.3 as a basis, a Void is submitted to void transaction #9991 when it is already in a voided state.

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
5	837	8	$100	A	4	7/1/09	7/1/09	323	9991	Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
6	835	7/2/09	323	4	$100	$0	9994	0

13.5 Original Approved, Replacement Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	$100	A	5	4/1/09	4/1/09	456		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	456	1	$100	$100	7771	5

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	$150	A	8	6/1/09	4/1/09	333	7771	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	456	22	($100)	($100)	7771	(5)
4	835	7/1/09	333	1	$150	$150	7772	8

13.6 Original Approved, Replacement Denied

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result

1	837	1	$200	A	1	4/1/09	4/1/09	678		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP04	CLP07	SVC05
2	835	5/1/09	678	1	$200	5551	1

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	$175	A	3	6/1/09	4/1/09	679	5551	Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	678	22	($200)	($200)	5551	(1)
4	835	7/1/09	679	4	$175	$0	5552	0

13.7 Replacement of a Denied Claim

Using the result of scenario 12.6, a replacement claim is submitted to replace the claim that was denied.

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
5	837	7	$125	A	1	7/15/09	4/1/09	680	5552	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
6	835	8/15/09	680	1	$125	$125	5553	1

13.8 Original Approved with Multiple Service Lines, Replacement Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	$250	A B	2 3	4/1/09	4/1/09	456		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	456	1	$100	$100	7771	A = 2 B = 3

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	$275	A C D	2 2 1	6/1/09	4/1/09	333	7771	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	456	22	($250)	($250)	7771	A = (2) B = (3)
4	835	7/1/09	333	1	$275	$275	7772	A = 2 C = 2 D = 1

13.9 Original with Multiple Service Lines Approved, Replacement Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	$250	A - $100 B - $150	2 3	4/1/09	4/1/09	456		A = Approved B = Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	456	1	$250	$250	7771	A = 2 B = 3

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM 01	ORN	Result
3	837	7	$250	A - $100 B - $150	2 2	6/1/09	4/1/09	333	7771	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	456	22	($250)	($250)	7771	A = (2) B = (3)
4	835	7/1/09	333	1	$250	$250	7772	A = 2 B = 2

13.10 Original Approved, Voided, and Replacement Denied

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	$200	A	1	4/1/09	4/1/09	678		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	678	1	$200	$200	5551	1

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	8	$200	A	1	4/1/09	4/1/09	679	5551	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	5/1/09	678	1	($200)	($200)	5551	(1)

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
5	837	7	$225	A	3	6/1/09	4/1/09	680	5551	Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
6	835	6/2/09	680	4	$225	$0	5552	0

13.11 Replacement of a Denied Claim

Using the result of scenario 12.10, a replacement claim is submitted to replace the claim that was denied.

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
7	837	7	$225	A	4	7/15/09	4/1/09	680	5552	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
8	835	8/15/09	680	1	$225	$225	5553	1

13.12 Original Partially Approved, Claim Split, Replacement of Denied Services

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	$385	A - $100 B - $150 C - $75 D - $60	2 3 3 1	4/1/09	4/1/09	9876		A = Approved B = Denied C = Denied D = Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	4/2/09	9876	4	$225	$0	7501	B = 0 C = 0

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	$225	B - $150 C - $75	4 3	4/09/09	4/1/09	9888	7501	Approved (B & C)

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	5/1/09	9876	1	$160	$160	7505	A = 2 D = 1

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
5	835	5/15/09	9888	1	$225	$225	7509	B = 4 C = 3

14.0 Unique ID

A Unique ID is required for each service line. The identification for each service line is the Line Item Sequence Number (LX01 in Loop 2400). In the 837P, if the Line Item Control Number (REF02 in Loop 2400) is populated, the SD/MC Phase 2 system will echo this service line identifier back on the corresponding 835 transaction, otherwise, the value from LX01 will be used on the 835.

The Line Item Sequence Number must begin with 1 for the first service line, and be incremented by one for each succeeding service line.

The Line Item Control Number (located in Loop 2400, REF Segment) may consist of any combination of upper and lower case characters. The system converts all characters to upper case for purposes of matching and duplicate edits. The remaining characters must be alphanumeric or any of the American Standard Code for Information Interchange (ASCII).

15.0 Other Health Coverage (OHC) Billing Scenarios

15.1 Presumed Denials

Under certain circumstances detailed in ADP Bulletin No. 11-01 and summarized in the following sections, trading partners may presume that a claim has been denied by an OHC carrier and bill ADP without receiving specific adjudication results (payment or denial) from the OHC carrier. When circumstances allowing such a presumed denial apply to a claim, Loop 2320 must be completed as if the OHC had adjudicated and denied the claim. The Loop 2320 Claim Level Adjustments (CAS) segment must be completed with a single adjustment, with the appropriate adjustment group code and adjustment reason code, and an adjustment amount equal to the Total Claim Charge Amount that was provided for the claim in Loop 2300 CLM02.

Unless a different group and reason code are specified for a particular circumstance, the Claim Level Adjustment for a presumed denial should be reported with group code “OA” in CAS01, and reason code “192” in CAS02.

Certain situations which allow presumed denials do not require the OHC carrier to be billed for the specific claim. ADP understands that certain trading partner billing systems are configured in a way that will cause the OHC to be billed if the identifying information for the OHC is included with the claim. Therefore, for situations identified below that can be billed as a presumed denial without billing the OHC for the specific claim, trading partners may complete Loop 2320 as follows:

- In Loop 2320 SBR–Other Subscriber Information segment

  - Do not populate Group or Policy Number (SBR03) or Group or Policy Name (SBR04) elements
  - Use "OT" (Other) for the Insurance Type Code (SBR05)
  - Use "ZZ" (Unknown) for the Claim Filing Indicator Code (SBR09)
- In Loop 2330A Other Subscriber Name (NM1) segment
  - Use "1" (Person) as the Entity Type Qualifier (NM102)
  - Use name of the client to populate the name fields (NM103–NM105, NM107)
  - Use "NOT REQUIRED" as the Other Insured Identifier (NM109)

Whenever a claim is submitted with a presumed OHC denial, documentation substantiating the circumstances permitting the use of the presumed denial must be retained for audit and monitoring purposes.

15.2 Delayed or No OHC Response

As stated in ADP Bulletin No. 11-01 (#1 and #2 under "Delayed or No OHC Response"), trading partners may presume that a claim submitted to an OHC carrier has been denied by the OHC when the provider has billed the service to the carrier, as required, and at least 90 days has past without a response from the OHC. When the requirements in ADP Bulletin #11-01 are met, this circumstance may be billed using the instructions for presumed denials in the previous subsection.

If, after the claim has been billed to DMC, payment is received from the OHC, a Replacement Claim must be submitted to update the Coordination of Benefits (COB) information for the claim to reflect the payment received.

If, after the claim has been billed to DMC, a denial is received from the OHC for a reason which does not permit billing DMC (as described in ADP Bulletin #11-01), then a Void Claim must be submitted to retract the claim submitted based on the presumed denial.

15.3 Prospective Denial Letter

As stated in ADP Bulletin No. 11-01 (#3 and #4 under "Delayed or No OHC Response"), trading partners may presume that a claim submitted to an OHC carrier has been denied when they have received an acceptable notification that future claims meeting specific criteria will not be accepted. When a service is provided in circumstance covered by a notice meeting the requirements laid out in ADP Bulletin #11-01, providers may bill the service to ADP using the instructions provided in § 15.2 for presumed denials, without first billing the service to the OHC. For these claims, the adjustment group and reason code identified in the Loop 2320 Claim Level Adjustments (CAS) segment should be the group and reason code from the code source identified in the Implementation Guide which best describes the reason for denial provided in the notification for the OHC.

15.4 Minor Consent Services for Clients with OHC

As described in ADP Bulletin No. 11-01, when Minor Consent Services are provided to clients who do not have a Minor Consent Aid Code (because they already have a full-scope, no-share-of-cost Medi-Cal eligibility), and the client has OHC with a scope of coverage that would

otherwise require the OHC to be billed before billing DMC, trading partners should bill DMC using the instructions in § 15.2 for presumed denials.

15.5 Medi-Cal Managed Care Plans coded as OHCs

ADP has received reports from counties and providers that some Medi-Cal Managed Care Plans (MCPs) have been coded in the State's Medi-Cal Eligibility Data System (MEDS) as if those MCPs were OHCs. ADP has confirmed with DHCS that MCPs are not OHCs and do not need to be billed before billing ADP for DMC services. If counties or providers encounter errors where MCPs are identified in Medi-Cal eligibility records as OHCs, they should contact the county office responsible for determining and updating Medi-Cal eligibility to correct the errors on the eligibility records. To facilitate claim submission and processing where such errors occur, claims may be submitted to ADP using the instructions in § 15.2 for presumed denials. The retained documentation supporting the use of the presumed denial mechanism for these claims must clearly demonstrate that the only applicable OHC on file for the client on the date of service with a Scope of Coverage that would otherwise require billing the OHC before ADP was a MCP, rather than an OHC that must be billed.

15.6 Unacceptable denial reasons given priority by OHCs

As stated in ADP Bulletin #11-01 (under "Appropriate OHC Denial or Adjustment Reasons"), denials received from OHCs that do not indicate that either the recipients coverage has been exhausted or the service received is not a benefit of the OHC are not acceptable for billing those services as DMC services to ADP. ADP has received reports from counties and providers that certain OHCs will deny services based on reasons that are unacceptable for DMC billing (such as that the provider is out of the OHC's network, or the services were not ordered by an in-network physician before being rendered) even when an acceptable denial reason for DMC billing (such as, the service is not a benefit of the OHC) also applies.

Provided that clear documentation from the OHC is received identifying that an acceptable denial reason exists for the particular claims (even if it is not the reason identified in the initial denial sent by the OHC), these claims may be billed to ADP with appropriate COB information. Both the original denial and the documentation supporting the acceptable denial reason must be maintained for audit and monitoring purposes.

16.0 Crosswalk Mappings and Other Tables

16.1 Table A - Delay Reason Code

HIPAA Delay Reason Code	HIPAA Descriptions	Description	PWK Required?
1	Proof of Eligibility Unknown or Unavailable	Patient or legal representative's failure to present Medi-Cal identification	No
7	Third Party Processing Delay	Billing involving other coverage including, but not limited to Medicare, Ross-Loos or CHAPMUS	No
8	Delay in Eligibility Determination	Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county.	Yes
4, 11	4 = Delay in Certifying Provider 11 = Other	Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster, willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable.	Yes
10	Administrative Delay in Prior Approval Process.	Special circumstances that cause a billing delay such as a court decision or fair hearing decision.	No
2	Litigation	Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC).	No
		Do not override late billing	

Please refer to, *Section 5.0 – Claim Supplemental Information - PWK Segment*, for further details about the PWK segment and its usage.

16.2 Table B - ICD-9 Codes

ICD-9-CM Diagnostic Code	ICD-9-CM Description
303.00	Acute Intoxication with Alcoholism
303.90	Other And Unspecified Alcohol Dependence - Unspecified
304.00	Opioid Type Dependence - Unspecified
304.10	Barbiturate And Similarly Acting Sedative Or Hypnotic Dependence - Unspecified
304.20	Cocaine Dependence - Unspecified
304.30	Cannabis Dependence - Unspecified
304.40	Amphetamine And Other Psychostimulant Dependence - Unspecified
304.50	Hallucinogen Dependence - Unspecified
304.60	Other Specified Drug Dependence - Unspecified
304.70	Combinations of Opioid Type Drug With Any Other - Unspecified
304.80	Combinations Of Drug Dependence Excluding Opioid Type Drug - Unspecified
304.90	Unspecified Drug Dependence - Unspecified
305.00	Alcohol Abuse - Unspecified
305.20	Cannabis Abuse - Unspecified
305.30	Hallucinogen Abuse - Unspecified
305.40	Barbiturate And Similarly Acting Sedative Or Hypnotic Abuse - Unspecified
305.50	Opioid Abuse - Unspecified
305.60	Cocaine Abuse - Unspecified
305.70	Amphetamine or Related Acting Sympathomimetic Abuse - Unspecified
305.80	Antidepressant Type Abuse - Unspecified
305.90	Other, Mixed, Or Unspecified Drug Abuse - Unspecified

16.2.1 Applying the "Fifth Digit"

The ICD-9-CM augments the DSM III/IV determination by requiring a fifth digit indicating the client's pattern of use. The available "fifth digits" and corresponding patterns of use are indicated in the following table:

Code	Pattern of Use	Alcohol Use	Drug Use
0	Unspecified	Not specified in documentation.	Not specified in documentation.
1	Continuous	Daily intake of large amounts of alcohol or regular heavy drinking on weekends or days off from work.	Daily, or almost daily, use of drugs.
2	Episodic	Alcoholic binges lasting weeks or months followed by long periods of sobriety.	Short periods between drug use, or use on weekends.
3	Remission	A complete cessation of alcohol intake or a period of time during which a decrease toward cessation is taking place.	A complete cessation of drug intake or a period of time during which a decrease toward cessation is taking place.

The following table provides a comparative illustration of ICD-9 fifth digit parameters with DSM III fifth digit parameters. The DSM III fifth digit definitions are not distinct for alcohol use and drug use.

Code	Course/ Pattern of Use[1]	DSM III/IV Definition	ICD-9 Definition	
			Alcohol Use	Drug Use
0	Unspecified	Course unknown or first signs of illness with respect to course uncertain.	Not specified in documentation.	Not specified in documentation.

Code	Course/ Pattern of Use[1]	DSM III/IV Definition	ICD-9 Definition	
			Alcohol Use	Drug Use
1	Continuous	More or less regular maladaptive use for over six months.	Daily intake of large amounts of alcohol or regular heavy drinking on weekends or days off from work.	Daily, or almost daily, use of drugs.
2	Episodic	A fairly circumscribed period of maladaptive use, with one or more similar periods in the past.	Alcoholic binges lasting weeks or months followed by long periods of sobriety.	Short periods between drug use, or use on weekends.
3	Remission	Previous maladaptive use, but not using substance at present. The differentiation of remission from no longer ill and from the other course categories requires consideration of the period of time since the last period of disturbance, the total duration of the disturbance and the need for continued evaluation for prophylactic treatment.	A complete cessation of alcohol intake or a period of time during which a decrease toward cessation is taking place.	A complete cessation of drug intake or a period of time during which a decrease toward cessation is taking place.

1 - The DSM-III uses the term “Course.”

16.3 Table C - Adjustment Reason Codes

Group Code	Adjustment Reason Code	Health Remark Code	Adjustment Reason Code Description
CO	10	N/A	Beneficiary identified as perinatal-eligible (Loop 2000B PAT09 is "Y"), but MEDS indicates this client is male.
CO	11	N/A	Perinatal service billed, but beneficiary is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided), or Daycare Rehabilitative service billed, but beneficiary is not EPSDT eligible per MEDS, and is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided.)
CO	16	N354	The claim (Original/Void/Replacement) is an invalid bridge resubmission claim.
CO	18	N/A	This service is not allowed on the same date as a previously-approved service for this beneficiary without a valid multiple service procedure modifier.
CO	22	N/A	MEDS indicates this client has non-Medicare other health coverage, and the claim does not indicate that that coverage has been billed first.
CO	23	N/A	Coordination of benefits adjustment.
CO	29	N/A	Claim denied for late submission.
CO	31	N/A	Beneficiary aid code(s) do not indicate eligibility for DMC services.
CO	45	N/A	Charges reduced because they exceed the maximum allowed given the established rate and the billed units of service.
CO	89	N/A	Administrative Fees retained by State.
CO	109	N/A	Claim denied because perinatal and non-perinatal services are billed together. Re-bill perinatal and non-perinatal services on separate claims.
CO	110	M52	Service date cannot be later than submission date.
CO	119	N345	Service line denied because a service (other than NTP counseling) was billed with a number of units different from the number of days billed.

Group Code	Adjustment Reason Code	Health Remark Code	Adjustment Reason Code Description
CO	119	N362	Service denied because it would exceed limit of 20 units of NTP counseling service per month for beneficiary.
CO	129	N/A	If Void or Replacement claim is submitted more than 6 months after the date of "Remittance Advice Issued" if approved, or date of "835 Sent" if denial.
CO	129	N59	Void or Replacement claim denied because the original claim is Bridge Resubmission claim.
CO	138	N/A	Claim denied because service dates on claim include more than one calendar month. Re-bill in separate claims for each calendar month of service.
CO	143	N/A	Portion of payment for approved services deferred due to insufficient contract balance.
CO	163	N/A	Claim denied because it was submitted late, a delay reason code requiring certification was provided and a certification attachment was referenced in the claim, but the certification attachment either was not received or did not cover this claim.
CO	167	M76	Service line denied because no diagnosis pointer provided in SV107 references a covered diagnosis code for DMC services.
CO	177	N/A	Claim denied because client is ineligible per MEDS.
CO	208	N257	Claim denied because Billing Provider EIN and NPI combination is not valid per ADP provider records.
CO	A1	M51	Service line denied because the procedure codes and modifiers provided do not identify a DMC service.
CO	A1	M59	Service line denied because service "to" date precedes "from" date.
CO	A1	M80	This service is not allowed on the same date as one or more previously-approved services for this beneficiary.
CO	A1	N63	Service line denied because a service other than NTP Methadone Dosing was billed with a date range rather than a single date of service.
CO	A1	N142	Void/Replacement claim denied because the original claim is an invalid resubmission claim.
CO	A1	N421	Service line denied due to disallowance from post-service, post-payment utilization review.

Group Code	Adjustment Reason Code	Health Remark Code	Adjustment Reason Code Description
CO	A1	N480	Claim or service line denied because COB information provided is not balanced. At the claim level, the Total Claim Charge Amount provided in the Loop 2300 Claim Information (CLM) segment must equal the Other Payer Paid Amount reported in Loop 2320 plus the sum of all adjustment amounts reported in Claims Adjustment (CAS) segments in Loops 2320 and Line Adjustment (CAS) segments in 2430 for this other payer. At the service line level, the Line Item Charge Amount provided in the Loop 2400 Professional Service (SVC) segment must equal the Service Line Paid Amount provided in the Loop 2430 Line Adjudication Information (SVD) segment, plus the sum of all Adjustment Amounts reported in Line Adjustment (CAS) segments in Loop 2430.
CO	B7	N/A	Service line denied because the Service Facility Location was not a DMC-certified site for the identified service on the date(s) of service.
CO	B7	MA114	Service line denied because the Service Facility Location is not one for which the Billing Provider may submit claims for the date(s) of service. If Service Facility Location provider type is 'Sole Proprietor' and the zip code +4 of SFL provider on claim/service line does not equal zip code +4 in ADP's provider file then deny service line.
PR	1	N/A	Service line reimbursement adjusted due to share of cost collected reported by provider.

Table D -PLB Adjustments

Adjustment Code	Rule
LE	IRS Levy
FB	Forwarding Balance
WO	Overpayment Recovery
72	Authorized Recovery
IS	Interim Settlement
PL	Payment Final: Blanket reduction due to an audit

16.4 Table E –Service Codes

Use HD in any procedure modifier position to indicate that the service is perinatal. Do not use HD if the service is not perinatal. Use H9 in any procedure modifier position to indicate that the service is provided to DMC-eligible clients under the Substance Abuse and Crime Prevention Act of 2000 (SACPA).

Service Group	Service	Procedure Code (Req)	Procedure Modifier 1	Procedure Modifier 2
DCR	Day Care Rehabilitative (Perinatal)	H0015	HD	
NTP	NTP-Individual Counseling (Perinatal)	H0004	HD	HG
NTP	NTP-Group Counseling (Perinatal)	H0005	HD	HG
NTP	NTP-Methadone (Perinatal)	H0020	HD	HG
ODF	ODF-Individual Counseling (Perinatal)	H0004	HD	
ODF	ODF - Group Counseling (Perinatal)	H0005	HD	
RES	Perinatal Residential (RES) (Short-Term)	H0018	HD	
RES	Perinatal Residential (RES) (Long-Term)	H0019	HD	

Service Group	Service	Procedure Code (Req)	Procedure Modifier 1	Procedure Modifier 2
DCR	Day Care Rehabilitative	H0015		
NAL	Naltrexone (NAL) generic	S5000	HG	
NAL	Naltrexone (NAL) brand name	S5001	HG	
NTP	NTP-Individual Counseling	H0004	HG	
NTP	NTP-Group Counseling	H0005	HG	
NTP	NTP-Methadone	H0020	HG	
ODF	ODF-Individual Counseling	H0004		
ODF	ODF - Group Counseling	H0005		

16.5 Table F -Duplicate Billing Edit Procedure Modifiers

Procedure Modifier	Modifier Description
59	Distinct Procedural Service
76	Repeat Procedure by Same person
77	Repeat Procedure by Different person